

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

22020

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... *St. Louis* Primary Registration District No. **0003**
 City..... *St. Louis* (No. *City Hospital # 2*) St. Ward)

2. FULL NAME

(a) Residence. No. *2932 1/2 Morgan St.* *21* Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred *1 1/2* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Col.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 6 1885*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 7 28

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *maid*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis, Mo.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Pate Jefferson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo.*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
 (STATE OR COUNTRY)

14. INFORMANT *Anna J. Woodard*
 (Address) *City Hospital # 2*

15. JUN - 9 1928
 FILED 19 *W. C. Stankoff*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 4, 1928*

17. I HEREBY CERTIFY, That I attended deceased from *5/28* 1928, to *6/4* 1928 that I last saw h. *in* alive on *6/4* 1928, and that death occurred on the date stated above, at *5:50 a.m.*

THE CAUSE OF DEATH* WOULD BE:
Labor Pneumonia
10:5

about (duration) yrs. mos. *9* ds.

CONTRIBUTORY (SECONDARY) *Ch. Myocarditi*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *not known*
 IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
 (Signed) *Red Howell*, M. D.
 , 19 (Address) *City Hospital # 2*

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENCE, CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Greenwood* DATE OF BURIAL *6/10 1928*

20. UNDERTAKER *A. Russell and Co. Pine St.*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

